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Issue date: 31Oct2001

In the Matter of

WILLIAM H. FRYE
Claimant

v.

CANNELTON INDUSTRIES, INC.
Employer

and

**DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS**
Party in Interest

Case No.: 1997-BLA-789

APPEARANCES: Mr. S. F. Raymond Smith, Attorney
For the Claimant

Mr. Paul Frampton, Attorney
For the Employer

BEFORE: Richard T. Stansell-Gamm
Administrative Law Judge

**DECISION AND ORDER ON REMAND FROM THE BENEFITS REVIEW BOARD -
AWARD OF BENEFITS**

This matter involves a claim filed by Mr. William H. Frye for benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 ("Act"). Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as "black lung" disease.

This Decision and Order on Remand represents my third evaluation of Mr. Frye's claim for benefits under the Act. My decision in this case is based on the testimony presented at the September 29, 1997

hearing and all documents admitted into evidence (DX 1 to DX 32, CX 1 to CX 4, and EX 1 to EX 4)¹.

Procedural Background

The procedural background of this case up to the time of the most recent decision by the Benefits Review Board (“BRB” or “Board”) was extensively covered in my September 8, 1999 Decision and Order On Remand and by the BRB in its November 29, 2000 Decision and Order. At this point, the most important aspects of this procedural history are the previous findings which have been affirmed by the BRB and thus become the “law of the case.”

First, in its April 21, 1999 Decision and Order, which reviewed my initial January 15, 1998 Decision and Order awarding benefits to Mr. Frye, the BRB affirmed the following findings:

A) Mr. Frye has twenty-nine and a half years of coal mine employment; Mr. Frye’s wife, Mrs. Daphne Frye, is a dependent for the purposes of augmenting any benefits payable under the Act; and Cannelton Industries is the responsible operator in this case.

B) Under 20 C.F.R. § 718.202 (a) (1), the preponderance of the chest x-ray evidence establishes the presence of pneumoconiosis in Mr. Frye’s lungs.

C) Since the preponderance of the chest x-ray evidence established the presence of pneumoconiosis, Mr. Frye had established a material change in conditions pursuant to 20 C.F.R. § 725.309.

D) Under 20 C.F.R. § 718.203, Mr. Frye’s pneumoconiosis arose out of his coal mine employment.

E) Mr. Frye is not able to establish the presence of a total disabling pulmonary or respiratory impairment under the provisions of 20 C.F.R. § 718.204 (c) (1) (pulmonary function tests) or 20 C.F.R. § 718.204 (c) (3) (presence of cor pulmonale with right sided congestive heart failure).

F) Mr. Frye is able to establish the presence of a total respiratory disability through arterial blood gas studies under 20 C.F.R. § 718.204 (c) (2).

¹The following notations appear in this decision to identify specific evidence: ALJ - Administrative Law Judge exhibit; DX - Director exhibit; CX - Claimant exhibit, EX - Employer exhibit; and, TR - Transcript of hearing. At the time of the hearing, DX 31 only contained a four page reference to Mr. Frye’s prior 1980 claim. On October 20, 1997, the District Director forwarded the first claim to the Office of Administrative Law Judges. The documents were labeled DX 33 - my request for the first claim; DX 34 - a thirty-one page copy of the first claim; and DX 35 - a revised referral letter. Since the parties to the hearing did not object to my receiving the first claim (TR, page 6 & 7), these three exhibits were admitted as DX 31 and replace the four page reference, which I marked as ALJ 3.

G) I appropriately weighed the opinions of Dr. Forehand, Dr. Rasmussen, and Dr. Zaldivar² on the issue of total respiratory impairment.

Second, in its November 29, 2000 Decision and Order, considering my September 8, 1999 Decision and Order on Remand again awarding benefits to Mr. Frye, the Board affirmed:

A) Its previous affirmation of my determination that under 20 C.F.R. § 718.202 (a) (1) the chest x-rays established the presence of pneumoconiosis.

B) My determination that Dr. Fino's medical opinion on issue of total disability was less probative than the opinions of Dr. Forehand and Dr. Rasmussen and also outweighed by their medical opinions.

C) My finding that the medical opinion in the record did not constitute sufficient contrary evidence to outweigh the preponderance of the arterial blood gas studies supportive of a finding of total disability under 20 C.F.R. § 718.204 (c) (2).³

ISSUES ON REMAND⁴

Although the BRB has affirmed multiple parts of my prior decisions on the various elements of entitlement, two key issues still remain to be resolved after the BRB's most recent review.

1. As required by a recent decision by the United States Court of Appeals for the Fourth Circuit,⁵ whether upon consideration and weighing of all types of evidence under 20 C.F.R. §§ 718.202 (a) (1) to (4), Mr. Frye has pneumoconiosis.

²The BRB did not agree with one of my factors for discounting Dr. Zaldivar, his solitary diagnosis of asthma. However, the Board found the remaining reasons sufficient to uphold my finding that his opinion had little probative weight.

³Based on the Employer's assertion on appeal that I inappropriately weighed the medical opinion in finding total disability under 20 C.F.R. § 718.204 (c) (4), the Board affirmed "the administrative law judge's finding that the medical opinion evidence establishes total disability." However, I based my finding of total disability on the qualifying blood gas studies under 20 C.F.R. § 718.204 (c) (2) (See September 8, 1999 Decision and Order on Remand, page 5). My assessment of the medical opinion at that stage involved determining whether the preponderance of the medical opinion provided sufficient contrary evidence to outweigh a total disability finding under 20 C.F.R. § 718.204 (c) (2). I concluded the medical opinion did not amount to contrary evidence. In a footnote (See September 9, 1999 Decision and Order on Remand, page 8, footnote 13), I further explained that rather than providing contrary evidence of total disability, I believed the more probative opinions of Dr. Forehand and Dr. Rasmussen on the issue of pulmonary impairment established that Mr. Frye was totally disabled.

⁴I informed counsel that I would accept briefs on the issues in this remand through March 15, 2001. Neither counsel submitted a brief.

⁵*See Island Creek Coal Co. v. Compton*, 211 F3d 203, (4th Cir. 2000).

2. If Mr. Frye suffers from pneumoconiosis, whether pneumoconiosis is at least a contributing cause of his total disability.⁶

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Issue No. 1 - Presence of Pneumoconiosis

“Pneumoconiosis” is defined as a chronic dust disease arising out of coal mine employment.⁷ The regulatory definitions include both clinical pneumoconiosis, the diseases recognized by the medical community as pneumoconiosis and legal pneumoconiosis, any chronic lung disease arising out of coal mine employment.⁸ As courts have noted, under the Act, the legal definition of pneumoconiosis is much broader than medical pneumoconiosis. *Kline v. Director, OWCP*, 877 F.2d 1175 (3d Cir. 1989).

According to 20 C.F.R. §718.202, the existence of pneumoconiosis may be established by four methods: chest x-rays (§718.202 (a)(1)), autopsy or biopsy report (§718.202 (a)(2)), regulatory presumption (§718.202 (a)(3)),⁹ and physician medical opinion (§718.202 (a)(4)). Because the official record does not contain any evidence of complicated pneumoconiosis and Mr. Frye’s duplicate claim was filed after January 1, 1982, a regulatory presumption of pneumoconiosis is not applicable. In addition, the official record obviously does not contain an autopsy report, and Mr. Frye has not submitted a biopsy report. As a result, Mr. Frye will have to rely on chest x-ray evidence or medical opinion to establish the presence of pneumoconiosis. In addition, under the guidance of *Compton*, I must consider both the chest x-ray evidence and medical opinion to determine whether Mr. Frye can establish pneumoconiosis.

⁶After noting that I permissively assigned less relative probative weight to the opinions of physicians who believed Mr. Frye did not have pneumoconiosis, the BRB nevertheless vacated my finding that Mr. Frye’s total disability was due to pneumoconiosis because it had vacated my pneumoconiosis finding in light of the *Compton* case. Consequently, my rationale for rejecting those medical opinions was no longer valid.

⁷20 C.F.R. §718.201. I will adjudicate this claim under the new regulations effective January 19, 2001. The provisions concerning the establishment of pneumoconiosis essentially remain the same.

⁸20 C.F.R. § 719.201 (a) (1) and (2).

⁹If any of the following presumptions are applicable, then under 20 C.F.R. §718.202 (a)(3) a miner is presumed to have suffered from pneumoconiosis: 20 C.F.R. §718.304 (if complicated pneumoconiosis is present then there is an irrebuttable presumption the miner is totally disabled due to pneumoconiosis); 20 C.F.R. §718.305 (for claims filed before January 1, 1982, if the miner has fifteen years or more coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and 20 C.F.R. §718.306 (a presumption when a survivor files a claim prior to June 30, 1982).

Chest X-Rays

Although the BRB has already affirmed my conclusion that the preponderance of the chest x-ray evidence supports a finding of pneumoconiosis, I will set out below both the summary of the radiographic films and then quote my reasoning from the January 15, 1998 Decision and Order.

Date of x-ray	Exhibit	Physician	Interpretation
July 9, 1981	DX 31	Bassham, BCR	Completely negative, no evidence of pneumoconiosis
(same)	DX 31	Smith, B, BCR	No evidence of pneumoconiosis
May 31, 1988 (read September 2, 1997)	EX 2	Abramowitz, B, BCR ¹⁰	Negative for pneumoconiosis, profusion 0/1, ¹¹ s/t, ¹² all right lung zones, mid & lower on left lung ¹³
(same) (read August 28, 1997)	EX 2	Gogineni, B, BCR	Negative for pneumoconiosis, profusion 0/1, s/t, upper right lung
September 15, 1992 (read September 2, 1997)	EX 2	Abramowitz, B, BCR	Negative for pneumoconiosis, profusion 0/1, s/t, all right lung fields, mid & lower on left lung

¹⁰B - B Reader; and BCR - Board Certified Radiologist. These designations indicate qualifications a person may possess to interpret x-ray film. A "B Reader" has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A "Board Certified Radiologist" has been certified, after four years of study and an examination, as proficient in interpreting x-ray films of all kinds including images of the lungs.

¹¹The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1 / 2 means the doctor's final determination is category 1 opacities but he considered placing the interpretation in category 2. Or, a reading of 0/0 means the doctor found no, or few, opacities and didn't see any marks that would cause him or her to seriously consider category 1.

¹²There are two general categories of small opacities defined by their shape: rounded and irregular. Within those categories the opacities are further defined by size. The round opacities are: type p (less than 1.5 millimeter (mm) in diameter), type q (1.5 to 3.0 mm), and type r (3.0 to 10.0 mm). The irregular opacities are: type s (less than 1.5 mm), type t (1.5 to 3.0 mm) and type u (3.0 to 10.0 mm). JOHN CRAFTON & ANDREW DOUGLAS, RESPIRATORY DISEASES 581 (3d ed. 1981).

¹³The x-ray interpretation form divides each lung into three zones. The doctor indicates the zone(s) containing the opacities.

(same) (read August 28, 1997)	EX 2	Gogineni, B, BCR	Negative for pneumoconiosis, profusion 0/1, s/t, upper right lung
February 1, 1993 (read September 2, 1997)	EX 2	Abramowitz, B, BCR	Negative for pneumoconiosis, profusion 0/1, s/t, all right lung fields, mid & lower on left lung
(same) (read August 28, 1997)	EX 2	Gogineni, B, BCR	No evidence of pneumoconiosis, left lower infiltrate
August 9, 1994 (read September 2, 1997)	EX 2	Abramowitz, B, BCR	Negative for pneumoconiosis, profusion 0/1, q/s/t, all right lung fields, mid & lower on left lung, minimal nodularity in upper left zone
(same) (read August 28, 1997)	EX 2	Gogineni, B, BCR	Negative for pneumoconiosis, profusion 0/1, s/q/t, upper right zone
October 5, 1995 (read September 2, 1997)	EX 2	Gogineni, B, BCR	Negative for pneumoconiosis, profusion 0/1, s/q/t, upper right zone, small nodule near left second rib
December 28, 1995 (read January 10, 1996)	DX 15	Francke, B, BCR	Negative for pneumoconiosis, profusion 0/1, u/u, upper two zones of the lung ¹⁴
(same) (read December 28, 1995)	DX 17	Forehand, B	No evidence of pneumoconiosis, right hilar ¹⁵ fullness
January 18, 1996 (read August 28, 1997)	EX 2	Gogineni, B, BCR	Negative for pneumoconiosis, profusion 0/1, s/t, upper zone, right lung
August 14, 1996 (read September 11, 1996)	DX 28	Zaldivar, B	No evidence of pneumoconiosis, large right hilar shadow, emphysema, and bullae ¹⁶
(same) (read September 8, 1997)	EX 1	Fino, B	Negative for pneumoconiosis, profusion 0/0 ¹⁷

¹⁴On the evaluation form, Dr. Francke indicated there were abnormalities in the lungs that were consistent with pneumoconiosis. However, while he considered profusion category 1, Dr. Francke apparently did not observe a sufficient number of marks to make profusion category 1 his final determination. The minimum x-ray profusion category that will support a finding of pneumoconiosis is category 1.

¹⁵Depression on the surface of the lung where the bronchus, blood vessels and nerves enter. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 767 (28th ed. 1994).

¹⁶Spaces more than 1 cm in diameter in the distended areas of an emphysematous lung. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 236 (28th ed. 1994).

¹⁷Although Dr. Fino enclosed two ILO classification forms with his consultative medical report, these ILO classification forms only indicate name, date and film grade. The 0/0 classifications appear in the text of Dr. Fino's medical report.

October 7, 1996 (read August 28, 1997)	EX 2	Gogineni, B, BCR	Negative for pneumoconiosis, profusion 0/1, s/t, upper right zone
March 17, 1997 (read March 25, 1997)	CX 2	Ahmed, B, BCR	Positive for pneumoconiosis, category 1/1, p/p, all six zones
(same) (read March 31, 1997)	CX 1	Pathak, B	Positive for pneumoconiosis, category 1 / 2, p/q, all six zones
(same) (read April 1, 1997)	CX 3	Cappiello, B, BCR	Positive for pneumoconiosis, category 1 / 2, p/q, all six zones
(same) (read September 8, 1997)	EX 1	Fino, B	Negative for pneumoconiosis, profusion 0/0

Starting on page 8 of my January 15, 1998 Decision and Order, I analyzed the portion of this radiographic evidence from 1988 through 1997 as follows:

A review of the radiographic interpretation evidence reveals a conflict in opinion as to whether x-rays show Mr. Frye has pneumoconiosis. In such cases, numerous guidelines exist for evaluating the diverse interpretations. First, the actual number of interpretation favorable and unfavorable may be a factor. *Wilt v. Wolverine Mining Co.*, 14 B.L.R. 1-70 (1990). At the same time, mechanical reliance on numerical superiority is not appropriate. *Akins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992). Second, consideration may be given to the evaluating physicians' qualifications and training. *Dixon v. North Camp Coal*, 8 BLR 1-344 (1985) and *Melink v. Consolidation Coal Company*, 16 B.L.R. 1-31 (1991). The interpretations from the doctors with the greater expertise may be accorded more evidentiary weight. *Taylor v. Director, OWCP*, 10 BRBS 449, BRB No. 77-610 BLA (1979). The qualifications of the doctor who provided the most recent evaluation may also bear on the evidentiary weight of the study. *McMath v. Director, OWCP*, 12 BLR 1-6 (1988).

On the basis of sheer numbers, negative interpretations outweigh the positive findings of pneumoconiosis. However, as mentioned above, mechanical reliance on numerical superiority is inappropriate. After carefully evaluating each interpretation and considering the qualifications of each physician, I reach the conclusion that the x-ray evidence does establish the presence of pneumoconiosis. I base my finding on ~~three~~ [two]¹⁸ factors. First, Dr. Abramowitz and Dr. Gogineni, both dual qualified radiologists,

¹⁸In my original decision, I listed as a third factor supporting a positive for pneumoconiosis finding, several evaluations of CT scans. Upon review, the BRB in the April 21, 1999 Decision and Order noted that CT scans are not considered part of the chest x-ray analysis under 20 C.F.R. § 718.202 (a) (1); instead, such evidence should be evaluated under 20 C.F.R. § 718.202 (a) (4). At the same time, the Board concluded my consideration of the CT scans

(continued...)

interpreted four x-rays taken between 1988 and 1994. While each interpretation is negative for pneumoconiosis, both doctors observed type s and t opacities in Mr. Frye's lung. In fact, Dr. Abramowitz found them in five of the six lung zones. Based on their observations, each doctors considered placing the profusion at category 1. In the end however, they made a final category assessment of 0. Then, Dr. Gogineni reviewed three more x-rays from 1995 and 1996 and reached the same conclusion; he saw type s opacities in Mr. Frye's right lung. Again, the profusion was not great enough for category 1. Next, another dual qualified radiologist, Dr. Francke, evaluated the December 1995 x-ray and noted type u opacities in the upper areas of Mr. Frye's lungs. He also concluded the profusion was not sufficient for category 1. I do note that Dr. Forehand looked at the same x-ray and found nothing. However, because Dr. Forehand has only a B Reader certification, I defer to Dr. Francke's more qualified opinion that there are opacities in Mr. Frye's lungs in December 1995. For the same reasons, I do not give equal probative weight to the interpretations of Dr. Zaldivar and Dr. Fino, both B Readers, that the August 1996 contains no opacities. The substantial preponderance of the x-ray evidence through 1996 shows the presence of opacities. While they are not sufficient in number to yield a positive interpretation for pneumoconiosis, this consistent interpretation by three highly qualified radiologists sets the foundation for the second factor.

Second, considering the progressive nature of black lung disease, under certain circumstances, the interpretations of the most recent x-ray may have significant probative value. Two dual qualified radiologists, Dr. Ahmed and Dr. Cappiello, found the opacities in the most recent x-ray, dated March 17, 1997, sufficient to reach category 1 and interpreted that x-ray as positive for pneumoconiosis. Dr. Pathak, a B Reader, also agreed with their assessment; whereas, Dr. Fino, also a B Reader saw nothing. The weight of the more qualified medical authority leads to the determination that the March 17, 1997 x-ray is positive for pneumoconiosis. Then, in light of the fact the x-ray history from 1988 through 1996 showed the existence of opacities and considering the progressive nature of pneumoconiosis, I find the positive March 1997 x-ray demonstrates that Mr. Frye has developed black lung disease.

I then subsequently concluded that the two earlier 1981 negative interpretations were not probative based on their age and thus did not alter my analysis of the chest x-ray evidence (January 15, 1998 Decision and Order, page 11). Consequently, I once again find that the interpretations by Dr. Ahmed, Dr. Pathak, and Dr. Cappiello of Mr. Frye's most recent x-ray to be the most probative and persuasive. As a result, the preponderance of the more probative chest x-ray evidence supports a finding of pneumoconiosis.

¹⁸(...continued)

under 20 C.F.R. § 718.202 (a) (1) was harmless error. I will provide a discussion on the CT scans in the medical opinion analysis.

Other Medical Evidence and Medical Opinion

Another regulatory basis for demonstrating the presence of pneumoconiosis is through other medical evidence and medical opinion under 20 C.F.R. § 718.202 (a) (4). Due to the reliance by several physicians on the blood gas studies in this case, I will first summarize those medical tests. Then, I will incorporate both the CT scan interpretations from my January 15, 1998 Decision and Order and the summarization of the medical opinion from earlier decisions.

Arterial Blood Gas Studies

Exhibit	Date/ Doctor	pCO₂	pO₂	Qualified¹⁹	Comments
DX 31	Jul 9, 1981 Buddington	39	69	No ²⁰	None.
DX 11	Dec 28, 1995 Forehand	31 (resting) 27 (exercise)	64 (resting) 67 (exercise)	Yes ²¹ Yes ²²	Hypoxia at rest and exercise ²³
DX 28	Aug 14, 1996 Zaldivar	35	73	No ²⁴	Not within normal range ²⁵

My analysis of this blood gas information started on page 15 of the January 15, 1998 Decision and Order.

Under the provision of 20 C.F.R. §718.204 (c) [(2)], if the preponderance of blood gas studies qualify under Appendix C of Section 718, then in the absence of evidence to the contrary, the blood gas study evidence shall establish a miner's total disability. This regulatory scheme requires a five step process. First, an administrative law

¹⁹To qualify for Federal Black Lung Disability Benefits, at a coal miner's given pCO₂ level, the value of the coal miner's pO₂ must be equal to or less than corresponding pO₂ value listed in the Blood Gas Tables in Appendix C of 20 C.F.R. §718.

²⁰For a pCO₂ value of 39, the qualifying pO₂ level is 61.

²¹For a pCO₂ value of 31, the qualifying pO₂ level is 69.

²²For a pCO₂ value of 27, the qualifying pO₂ level is 73.

²³Dr. J. Michos for DOL reviewed the test for DOL and determined it was technically acceptable (DX 13).

²⁴For a pCO₂ value of 35, the qualifying pO₂ level is 65.

²⁵Due to Mr. Frye's prior heart attack in 1980, Dr. Zaldivar did not conduct an exercise test.

judge must determine whether the tests conform to the blood gas study procedure requirements in 20 C.F.R. §718.105. Second, the test results are compared to the pO_2 qualifying numbers listed in Appendix C to determine whether the tests show total disability. Third, an administrative law judge must evaluate any medical opinion that questions the validity of the test results. See *Vivian v. Director, OWCP [Alley]*, 897 F.2d 1045 (10th Cir. 1990). Fourth, a determination must be made whether the preponderance of the conforming and valid blood gas studies supports a finding of total disability under the regulation. Fifth, if the preponderance of conforming blood gas tests establishes total disability under the regulation, an administrative law judge then reviews all the evidence of record and determines whether the record contains “contrary probative evidence.” If there is contrary evidence, then it must be given appropriate evidentiary weight and a determination is then made to see if it outweighs the blood gas study evidence that supports a finding of total respiratory disability. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987).

With these steps in mind, I first reviewed the blood gas studies for conformance to the regulatory testing standards. Because the results of both the 1981 test (DX 31) and the 1995 test (DX 11) were printed on DOL forms and contain all the information required under the regulations, both studies are conforming. Dr. Michos also reviewed the 1995 test documents and determined the study was technically acceptable (DX 13). On the other hand, the 1996 test (DX 28) by Dr. Zaldivar lacks at least three items of information: test site altitude, pulse rate at the time the blood was drawn, and confirmation that the test equipment was calibrated before and after the test.²⁶ Since the test was administered in Charleston, West Virginia, the altitude information can be obtained from other sources. However, the other two requirements may be more important in establishing confidence in the validity of the results. The absence of this information makes the test non-conforming.

Next, in comparing all the test results with Appendix C of Section 718, two of four tests qualify. Both the “at rest” and “exercise” pO_2 values from the 1995 are under the threshold requirement for total disability in Appendix C for the corresponding pCO_2 .

Third, Dr. Zaldivar in his deposition mentions Mr. Frye’s heart condition in discussing the blood gas tests (EX 4, page 22). However, he does not specifically invalidate the test result on the basis of cardiac disease nor does he explain how it might effect the test results. I find the test results have not been sufficiently challenged by medical opinion.

²⁶20 C.F.R. §718.105 (c) (2), (8), and (10).

Fourth, in weighing the conforming tests results from July 1981 (non-qualifying) and 1995 (qualifying), I note the 1981 results are consistent with the determination in the first claim that Mr. Frye did not have pneumoconiosis. At the same time, the 1995 test presents a more recent assessment of Mr. Frye's ability to get oxygen into his blood stream. In weighing the two conforming arterial blood gas studies, I give greater probative weight to the 1995 study and find blood gas test evidence supports a finding of total respiratory disability.

Even if the 1996 blood gas study had conformed to regulatory reporting standards, I would still find the 1995 "exercise" study the most probative because it provides a snapshot of Mr. Frye's oxygen exchange capability while under physical stress. Although the 1996 "at rest" test did not show total disability, the study did not include an exercise portion. In light of the strenuous nature of Mr. Frye's last coal job, I believe the most accurate assessment of whether he has the respiratory capacity to return to work is how well his lungs function under heavy physical activity. The one exercise test in the official record from 1995 shows his lungs are not effective at getting oxygen into the blood during physical activity. Also, in terms of preponderance of the evidence, out of the three most recent and probative blood gas studies accomplished in 1995 and 1996, two of the tests yielded qualifying numbers.

At this point of the analysis, I then reviewed the medical opinion in the record to ascertain whether it amounted to sufficient contrary evidence. It did not

Medical Opinion

The following medical opinion summaries come from pages 16 to 18 of the January 15, 1998 Decision and Order and pages 5 to 7 of the September 8, 1999 Decision and Order.

[Dr. Buddington]

In July 1981, Dr. R. Buddington conducted the first Black Lung Act benefits examination of Mr. Frye (DX 31). Mr. Frye described his thirty years of coal mine employment and indicated he left coal mining following a heart attack in January 1980. Although he smoked for twenty-six years at the rate of 1/2 pack of cigarettes a day, Mr. Frye quit smoking in 1964. He complained about shortness of breath when walking at a brisk pace. The physical examination was normal, the lungs were clear. The pulmonary function tests were also normal. The arterial blood gas study showed some hypoxemia²⁷ at rest. Based on Mr. Frye's history and the blood gas test, Dr. Buddington found he had

²⁷Deficient oxygenation of the blood. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 812 (28th ed. 1994).

a slight chronic respiratory impairment. Dr. Buddington's diagnosis included slight chronic pulmonary disease, history of myocardial infarction²⁸, and angina pectoris.²⁹ Dr. Buddington noted there was no evidence of congestive heart failure. Because he was not able to obtain a copy of the x-ray interpretation, Dr. Buddington did not reach a conclusion as to whether exposure to coal dust had caused the pulmonary disease. He did state that any cardiac disease "did **not** influence the pulmonary findings."

[Dr. Forehand]

Following the submission of Mr. Frye's second claim, Dr. J. Forehand, board certified in allergy, immunology, and pediatrics,³⁰ evaluated Mr. Frye for black lung disease in December 1995 (DX 10). Mr. Frye gave Dr. Forehand an employment history of thirty years in the coal mines and medical history which included a 1980 hospitalization for cardiac problems. Mr. Frye also stated he had smoked cigarettes for twenty years at the rate of two packs every three days. The physical examination revealed no health problems. The chest x-ray was negative for pneumoconiosis, and the pulmonary function tests were within normal limits. On the other hand, the blood gas tests revealed hypoxemia both at rest and during exercise. An electrocardiogram had normal tracings. Dr. Forehand diagnosed chronic bronchitis and found no evidence of pneumoconiosis. Based on Mr. Frye's smoking history and the negative chest x-ray, he listed smoking as the cause of the pulmonary impairment. Dr. Forehand also found Mr. Frye was totally disabled by the chronic bronchitis based on the blood gas study.

[Dr. Zaldivar]

In August 1996, Dr. G. Zaldivar, board certified in internal medicine and pulmonary disease, also examined Mr. Frye (DX 28 and EX 4). Again, Mr. Frye presented a thirty year history of coal mine work and a medical history that included the 1980 heart attack. Mr. Frye also discussed his chronic breathing problems. During the physical examination, Dr. Zaldivar noted wheezes upon expiration. The pulmonary function tests showed a moderate diffusion impairment. The blood gas study confirmed Mr. Frye was a non-smoker; and, while outside normal limits, the results did not qualify as totally disabling. Dr. Zaldivar also conducted a review of Mr. Frye's medical records

²⁸Heart muscle tissue damage due to the interruption of the blood supply to the area. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 837 (28th ed. 1994).

²⁹A spasmodic, choking or suffocating pain in the chest. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 77 (28th ed. 1994).

³⁰Although I should have provided prior notice to the parties, I take judicial notice of Dr. Forehand's board certification. I have attached a copy of the certification documentation.

and noted his smoking history. Dr. Zaldivar considered the x-ray evidence to be negative for pneumoconiosis. The electrocardiogram reading was abnormal and showed an AV³¹ block. Based on his own examination and review of the record, Dr. Zaldivar reached several conclusions. First, Mr. Frye's breathing problems, based on the wheezes and coughing, were related to asthma that was aggravated by Mr. Frye's use of an inhaler for his heart condition (Propranolol). Second, due to a localized mass in the x-ray, Dr. Zaldivar believed Mr. Frye might have cancer which would be responsible for the diffusion impairment. Third, Mr. Frye had coronary artery disease which was causing him chest pain when exercising. Fourth, Mr. Frye did not have pneumoconiosis and from a pulmonary perspective, Mr. Frye had the capacity to return to his last coal mine employment. Because the pulmonary function tests did not show total disability, sufficient airflow was getting to Mr. Frye's lungs to allow him to perform his usual coal mine employment. When asked at his deposition to consider the 1995 blood gas test results which met the total disability thresholds, Dr. Zaldivar stated, "As for the examination of Dr. Forehand, the blood gases obtained by him are not disabling anyway, and would allow him [Mr. Frye] to perform arduous manual labor" (EX 4, page 22). He further explained, that while a pO₂ level in the 60s was not normal, he believed the pO₂ level had to be below 60 on an acute or chronic basis to show an exercise limitation due to hypoxemia. Fifth, even if Mr. Frye had "simple" pneumoconiosis, Dr. Zaldivar's assessment of his pulmonary condition would remain unchanged.

[Dr. Rasmussen]

In June 1997, Dr. D. Rasmussen, board certified in internal medicine,³² reviewed the medical reports of Dr. Forehand and Dr. Zaldivar and the evaluations of the most recent chest x-ray (CX 4). Dr. Rasmussen noted the 1995 blood gas tests showed a totally disabling respiratory impairment. He questioned Dr. Forehand's assessment that the respiratory disability was due to bronchitis because the pulmonary function tests were normal. He also questioned Dr. Zaldivar's statement that the diffusion impairment may be due to cancer because the relationship was unexplained and there had been no definitive finding of lung cancer. Instead, Dr. Rasmussen believed the 1997 positive chest x-ray and the 1995 blood gas study coupled with Dr. Zaldivar's pulmonary test showing a diffusion impairment clearly established that Mr. Frye had a significant gas exchange impairment that was totally disabling. Dr. Rasmussen observed there were two risk factors associated with the pulmonary impairment, past cigarette smoking and coal mine employment. He

³¹AV - atrioventricular (relating to a heart chamber and ventricle). DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 164, 157 (28th ed. 1994).

³²I take judicial notice of Dr. Rasmussen's board certification and have attached a copy of the certification documentation.

concluded that based on the near normal ventilatory functions and the abnormal blood gas exchange capability, exposure to coal mine dust was the most important factor in Mr. Frye's pulmonary impairment.

[Dr. Fino]

Dr. G. Fino, board certified in pulmonary disease and internal medicine, reviewed the medical evidence from 1995 to 1997 (EX 1). Dr. Fino first concluded by review of other interpretations and his own assessment that the x-ray evidence did not establish the presence of pneumoconiosis. He next noted that since the 1996 resting blood gas test did not qualify as totally disabling, whatever caused the significant impairment in 1995 had resolved itself. If pneumoconiosis were the cause of the blood gas exchange problem, he would expect to see disabling results in 1996, but that did not happen. In addition, considering Mr. Frye did not have pneumoconiosis, that disease could not be the cause of Mr. Frye's breathing problems. Concerning the diffusion problem, Dr. Fino believed a tumor may be responsible. In conclusion, Dr. Fino stated Mr. Frye did not have pneumoconiosis, was not totally disabled, and did not have a respiratory impairment.

CT Scan Interpretations

The CT interpretations were summarized at page 9 of the January 15, 1998 Decision and Order.

Dr. Abramowitz provided interpretations of two CTs³³ of Mr. Frye's lungs (EX 2). In the images from an April 1996 CT, he did not find a definite hilar mediastinal adenopathy.³⁴ Dr. Abramowitz did observe 'mild generalized increase in interstitial³⁵ markings throughout the lungs' and 'bilateral pleural³⁶ plaque compatible with prior exposure to asbestos fibers.' Concerning this CT, Dr. Abramowitz concluded, 'there is nonspecific interstitial lung disease.' Dr. Abramowitz also reviewed the CT images that were obtained a year later in April 1997. Again, he noted the same lack of adenopathy in the hilar, and the pleural plaque. Dr. Abramowitz also observed a 'generalized increase in interstitial markings throughout the lungs.' This CT also revealed for the first time a less than 1 cm nodule in the right lung.

³³CT - computed tomography. Basically, internal body x-ray images at a predetermined plane. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 1718 (28th ed. 1994).

³⁴Mediastinal refers to the tissues and organs between the two lungs and adenopathy is enlargement of glands. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 998, 28 (28th ed. 1994).

³⁵The inter-space of tissue. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 851 (28th ed. 1994).

³⁶The membrane surrounding the lungs. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 1307 (28th ed. 1994).

Discussion

Because the chest radiographic evidence supports a finding of pneumoconiosis, I turn to consideration of the other evidence in the record in this case, consisting of medical opinion and CT scan interpretations, specifically to determine whether the preponderance of all the relevant evidence in the record supports a finding under 20 C.F.R. § 718.202 (a) that Mr. Frye has pneumoconiosis.

Turning first to the CT scan interpretations by Dr. Abramowitz, I find his assessment are tangentially supportive of a finding of pneumoconiosis. As I stated on page 10 of my January 15, 1998 Decision and Order:

both of Dr. Abramowitz's observations are relevant and probative as to whether the March 1997 x-ray images revealed pneumoconiosis. Most importantly, his interpretations of interstitial markings throughout the lungs corroborate the 1988 to 1996 x-ray interpretations that some type of opacities are present in Mr. Frye's lungs. Dr. Abramowitz's comments on the first CT that the interstitial markings throughout Mr. Frye's lungs are mild are consistent with his interpretations of Mr. Frye's x-rays, through August 1994, in which he found type s and t opacities throughout the right lung and the lower two zones of the left lung, but listed the profusion as 0/1. His CT comments are also in line with the preponderance of the x-ray evaluations through December 1995. Finally, when Dr. Abramowitz rendered his evaluation of the second CT that was taken within one month of the most recent x-ray, he no longer characterized the interstitial markings as "mild" which provides some corroboration for the determinations by Dr. Ahmed, Dr. Pathak, and Dr. Cappiello that the profusion was now sufficient for a positive finding of pneumoconiosis.

Next, due to the conflict of medical opinion, I must initially assign relative probative weight to the medical assessments. In evaluating medical opinions, an administrative law judge must first determine whether opinions are based on objective documentation and then consider whether the conclusions are reasonable in light of that documentation. A well-documented opinion is based on clinical findings, physical examinations, symptoms, and a patient's work history. See *Fields v. Island Creek Coal Company*, 10 B.L.R. 1-19 (1987) and *Hoffman v. B & G Construction Company*, 8 B.L.R. 1-65 (1985). For a medical opinion to be "reasoned," the underlying documentation and data should be sufficient to support the doctor's conclusion. See *Fields, supra*. In evaluating conflicting medical reports, as with x-ray analysis, it may be appropriate to give more probable weight to the most recent report. See *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149(1989)(en banc). At the same time, "recency" by itself may be an arbitrary benchmark. See *Thorn v. Itmann Coal Co.*, 3 F.3d 713 (4th Cir. 1993). A medical opinion may be given little weight if it is vague or equivocal. See *Griffith v. Director, OWCP*, 49 F.3d 184 (6th Cir. 1995) and *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988).

In regards to relative probative weight, I find, as in my first decision, that Dr. Buddington's 1981 evaluation has little probative value due to its age.

As previously discussed in my earlier opinions, for several reasons,³⁷ I give little relative probative weight to Dr. Zaldivar's medical opinion, because it is not well reasoned and I have little confidence in the integrity of the decision. First, due to the importance of fully considering all the medical evidence on the subject of pneumoconiosis, Dr. Zaldivar demonstrated a propensity to disregard information that conflicted with his conclusions. Notably, "when Dr. Zaldivar concluded there was no respiratory disability, he relied primarily on the pulmonary function tests that indicated there was sufficient airflow to Mr. Frye's lungs. At the same time, even though he had reviewed the 1995 disabling blood gas test results, he did not state in his initial report" how this qualifying report of blood gases fit into his diagnosis that Mr. Frye did not suffer any disability.

Second, in addition to disregarding contrary medical evidence, Dr. Zaldivar also went to great lengths to alter the meaning of test results that didn't support his decision. For example,

when Dr. Zaldivar was asked about the 1995 "exercise" blood gas test, he stated, "the blood gases remained normal, which means there is no lack of oxygen that would prevent him from performing his usual work." Dr. Zaldivar was asked to correlate the 1995 blood gas test results that under the regulations showed total disability with his absence of respiratory disability diagnosis. He declared the test results were not disabling because the pO_2 was still in the 60s. He would not diagnose disability unless the pO_2 value fell below 60. Dr. Zaldivar's position concerning the 1995 tests is unreasonable and clearly contrary to Appendix C of the regulation that does permit a finding of total disability when pO_2 values are in the 60s.

Finally, Dr. Zaldivar seemed to concentrate on clinical pneumoconiosis without broadening his analysis to include legal pneumoconiosis. In defending his disability diagnosis, "Dr. Zaldivar, again without any explanation, states that even if Mr. Frye had pneumoconiosis, it would not alter his conclusions because the breathing test results were not compatible with the presence of pneumoconiosis. Yet, Dr. Zaldivar's pulmonary tests showed a diffusion impairment and the 1995 blood gas studies revealed an oxygen exchange impairment in the lungs," problems that may be related both clinical and legal pneumoconiosis.

In regards to Dr. Fino's assessment that Mr. Frye does not have pneumoconiosis, I give his opinion on the issue diminished probative weight principally because he inappropriately relies on a 1996 blood gas study which did not conform to the regulations to explain away the possibility of pneumoconiosis. After concluding the chest x-rays were negative, Dr. Fino focused on the non-qualifying resting blood gas study of 1996 to explain how pneumoconiosis could not be the cause of Mr. Frye's breathing problems because the improvement in blood gas test results was inconsistent with the permanent nature of pneumoconiosis. However, due to various documentary discrepancies, I found the 1996 blood gas study non-conforming and consequently not reliable medical evidence. As a result, his reliance on that test renders his opinion

³⁷See footnote 2.

less documented and reasoned.³⁸ In addition, I observe that Dr. Fino's prompt dismissal of Mr. Frye's demonstrated breathing problem as possibly due to a tumor, discloses a failure to fully consider how legal pneumoconiosis might be applicable in Mr. Frye's case.

Although in my prior decisions, I found (and the BRB affirmed my determination) the opinions of the remaining two physicians, Dr. Forehand and Dr. Rasmussen, to be most probative on the issue of total disability, I reach a different conclusion about Dr. Forehand's assessment on the issue of pneumoconiosis. Specifically, I consider his opinion about the absence of pneumoconiosis to be less probative than Dr. Rasmussen's opinion that Mr. Frye has the lung disease. In a manner similar to Dr. Zaldivar, Dr. Forehand's medical opinion has diminished relative probative weight because he seems to focus on clinical pneumoconiosis. Since he believed the chest x-ray evidence was negative, a typical method for discovering clinical pneumoconiosis, Dr. Forehand concluded that the negative radiographic evidence coupled with Mr. Frye's past cigarette smoking habit established that his chronic, disabling bronchitis was due solely to cigarette smoke. Dr. Forehand reached that conclusion without explaining how he eliminated Mr. Frye's nearly thirty years of exposure to coal mine dust as a possible cause of Mr. Frye's bronchitis. Under the regulatory definition of legal pneumoconiosis, if Mr. Frye's long term exposure to coal dust was significantly related to the bronchitis, then he may be considered to have legal pneumoconiosis.

On the other hand, in relative probative terms, Dr. Rasmussen rendered the best reasoned medical opinion on the presence of pneumoconiosis which is most consistent with both Mr. Frye's coal mine employment background, his smoking history, and the medical test results. Dr. Rasmussen demonstrated a willingness to consider both clinical and legal pneumoconiosis in his evaluation of Mr. Frye. He further integrated the pulmonary test and the blood gas studies in concluding that of the two potential causes for Mr. Frye's breathing problems, his exposure to coal dust was the most important factor. And, by addressing many of the other medical opinions in the record, he presented the best documented decision.³⁹

Summary

Considering all the medical evidence in the record, I find that the preponderance of the probative chest x-ray evidence, as supported by Dr. Rasmussen's most probative medical opinion, and further corroborated by the CT scan interpretations, establishes the presence of pneumoconiosis in Mr. Frye's

³⁸See *Arnoni v. Director, OWCP*, 6 B.L.R. 1-423 (1983) (administrative law judge properly discredited a medical opinion that was based in part on a non-conforming ventilatory study).

³⁹I note that if I had considered Dr. Forehand's and Dr. Rasmussen's medical opinions about the presence of pneumoconiosis equally probative, the probative medical opinion on that issue would then stand in equipoise and consequently be insufficient to overcome the establishment of pneumoconiosis through the preponderance of the probative chest x-ray evidence.

lungs. Accordingly, Mr. Frye has established the first necessary element of entitlement under the Act.⁴⁰

Issue No. 2 - Causation of Disability

The BRB vacated my determination that pneumoconiosis was at least a contributing cause of Mr. Frye's total respiratory disability primarily because my weighing of the medical opinion on this issue was clearly affected by my determination that Mr. Frye had pneumoconiosis. Since the Board concluded I needed to reassess my pneumoconiosis finding, it also set aside my finding on total disability causation.

Now, since I have again determined, upon weighing all the relevant evidence on the issue, that Mr. Frye has pneumoconiosis, I incorporate and adopt my previous analysis, findings and conclusion from September 1999 that Mr. Frye's pneumoconiosis is due, at least in part, to pneumoconiosis as follows:

Since there is no evidence of complicated pneumoconiosis, and Mr. Frye filed his second claim after 1982, he is not able to rely on any of the regulatory presumptions. Instead, medical evidence in the record will determine whether Mr. Frye's total disability is due to pneumoconiosis.

Because Dr. Buddington did not discuss the presence or absence of pneumoconiosis due to the unavailability of x-ray evidence, the medical evidence on this issue consists of the four medical opinions of Dr. Zaldivar, Dr. Fino, Dr. Forehand, and Dr. Rasmussen. Since Dr. Fino and Dr. Forehand concluded Mr. Frye did not have pneumoconiosis, their opinions on whether pneumoconiosis contributed to Mr. Frye's total disability carry little probative weight in light of my finding that Mr. Frye does have pneumoconiosis. See, *Hobbs v. Clinchfield Coal Co.*, 45 F.3d 819 (4th Cir. 1995). Likewise, I find little probative value in Dr. Zaldivar's evaluation on whether pneumoconiosis contributed to Mr. Frye's total respiratory disability because he opined Mr. Frye did not have a total respiratory disability.⁴¹ On the other hand, Dr. Rasmussen, the one physician who did diagnose the presence of pneumoconiosis, identified cigarette smoking and coal mine employment as the two potential causes of Mr. Frye's respiratory impairment. Based on the medical evidence, he concluded coal mine employment was the most significant factor in Mr. Frye's pulmonary disability. I find his conclusion well documented and reasoned. In the absence of contrary probative medical opinion, Dr. Rasmussen's conclusion establishes that Mr. Frye's total disability is due, at least in part, to pneumoconiosis.

⁴⁰I also specifically find once again, that by proving he has pneumoconiosis, Mr. Frye has established a material change in conditions since the denial of his prior claim under 20 C.F.R. § 725.309.

⁴¹Similarly, Dr. Fino's opinion on this issue is further diminished because he also did not find Mr. Frye totally disabled by a respiratory impairment.

Consequently, Mr. Frye again establishes the fourth entitlement element, total disability due to pneumoconiosis.

CONCLUSION

Through the preponderance of chest x-ray evidence, the more probative medical opinion of Dr. Rasmussen, in conjunction with supporting CT scans, Mr. Frye has proven that he has pneumoconiosis. The Board has previously affirmed my finding under 20 C.F.R. § 718.203 that his pneumoconiosis arose out of his twenty-nine and a half years of coal mine employment. The BRB has also upheld my determination that the contrary evidence in the record did not outweigh a finding that Mr. Frye had a total respiratory impairment established under 20 C.F.R. § 718.204 (c) (2) through qualifying blood gas studies. And, I again find that since Mr. Frye has pneumoconiosis, the most probative assessment of Dr. Rasmussen (as affirmed by the BRB) demonstrates that Mr. Frye's total respiratory impairment is due to pneumoconiosis. Having established all four necessary elements of entitlement, Mr. Frye is entitled to benefits under the Act. As I have also previously determined, based on the month Mr. Frye filed this present claim, the date of entitlement is November 1, 1995.

ATTORNEY FEES

Counsel for the Claimant has thirty days from receipt of this decision to submit an additional application for attorney fees related to this remand in accordance with 20 C.F.R. §§ 725.365 and 725.366. With the application, counsel must attach a document showing service of the fee application upon all parties, including the Claimant. The other parties have fifteen days from receipt of the fee application to file an objection to the request. Absent an approved application, no fee may be charged for representation services associated with the claim.

ORDER

The claim of MR. WILLIAM H. FRYE for benefits under the Act is **GRANTED**. CANNELTON INDUSTRIES, INC., is ordered to pay the Claimant all benefits to which he is entitled under the Act and Regulations, augmented for one dependent, MRS. DAPHNE FRYE. Benefits shall commence November 1, 1995.

SO ORDERED:

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RICHARD T. STANSELL-GAMM

Administrative Law Judge

Date Signed: October 31, 2001
Washington, D.C.

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. §725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this decision is filed with the District Director, Office of Worker's Compensation Programs, by filing a notice of appeal with the Benefits Review Board, ATTN.: Clerk of the Board, Post Office Box 37601, Washington, DC 20013-7601. See 20 C.F.R. §725.478 and §725.479. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2605, 200 Constitution Avenue, NW, Washington, DC 20210.